

# Treating Normal-Weight Bulimia Nervosa

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# Eating Disorders

- Better referred to as “pursuit of thinness” disorders
  - In the context of caloric deprivation and weight loss, binge eating makes sense
  - Nonetheless, the specific features required for the diagnosis of BN are binge eating and compensatory behaviors such as vomiting or laxative abuse

# DSM-IV Criteria for BN

- A. Recurrent episodes of binge-eating. An episode of binge-eating is characterized by both of the following:
  - Eating, in a discrete period, an amt of food definitely larger than most people would eat in similar circumstances
  - A sense of lack of control of eating during the episode

# DSM-IV Criteria for BN

- B. Recurrent inappropriate compensatory behavior in order to prevent wt gain, such as vomiting, laxative abuse, diuretics, enemas, other meds, fasting or excessive exercise
- C. Binge-eating and compensatory behaviors happen, on average, at least 2x/wk for 3 months

# DSM-IV Criteria for BN

- Self-evaluation unduly influenced by body shape and weight
- Disturbance not only during AN
- Subtypes: purging/non-purging

# Epidemiology of Dieting/ED's

- BN occurs in cultures where:
  - 1. Food is easily obtained by most
  - 2. Obesity is frequent compared to emaciation
  - 3. A premium is placed on slimness/attractiveness
- Dieting is frequent in these circumstances
- For example, about 90% of college freshman women diet, 2% have BN, but nearly 10X that many are at risk with subclinical sx of BN
- Starved nl males get similar sx (Keys study @ UM)

# Phenomenology of BN

- Recurrent binge eating:
  - Lab studies show that some binge 3-5,000 cal/binge
  - High fat foods that are usually avoided
  - Loss of control-animal-like intake vs inability to avoid ritualized behaviors
- Vomiting:
  - repulsive to others but brings sense of control and calm;
  - results in large water loss that is short-lived;
  - doesn't work due to failure to empty stomach completely

# Phenomenology of BN

- Laxative Abuse
  - Also results in large water loss
  - Can result in hypotonic colon and colostomy
- Can also use fasting and excessive exercise
- Binge-purge cycle

# Phenomenology of BN

- Co-morbid mental disorders: mood, anxiety, substance abuse, shoplifting, suicide attempts, borderline PD
- Co-morbid physical disorders: low energy, abdominal pain, constipation, amenorrhea, decreased bone density, electrolyte disturbances (which can cause cardiac arrhythmia and death), hematemesis

# Treatment

- Diagnosis: best tool is frank, specific questions about food intake
  - Eg “What did you have for dinner last night?”
  - As opposed to “Are you eating OK?”

# Treatment

- Goals
  - 1. Stop binges and purges
  - 2. Eat according to a healthy plan and accept the body that results
  - 3. Decrease comorbid symptoms
  - 4. Decrease the dependence of one's self-esteem on body shape and weight

# Treatment

- Motivation/Ambivalence
  - Often in precontemplation or contemplation phase
  - While younger patients can often be pressured to start a treatment, older patients need more often to make a commitment
  - Use same motivational interviewing techniques described by Miller for ETOH problems

# Treatment

- Setting
  - Majority as outpatient (sometimes intensive outpatient or partial hospital; these settings allow intense psychoeducational and cognitive-behavioral interventions regarding meal planning and eating, mood management, problem-solving, and body image)
  - Episodic hospitalization for suicidal episodes, hypovolemia, hypokalemia

# Treatment

- Sequence of treatment for comorbid states:
  - Alcohol before BN or vice versa
  - Vs simultaneous
  - CBT, ME, and 12-step all work for both

# Treatment

- Psychotherapy
  - CBT effective, but so is IPT
    - Over 20 randomized trials show efficacy
    - CBT is quicker than IPT and more complete and lasting than pharmacotherapy
    - Manuals are available for both CBT and IPT
    - Unfortunately, few therapists do these treatments as described in the manuals
    - BN still fails 50%; new therapies such as DBT for BN are still being developed

# Typical Content

- Education re: Body Image and Culture/Dieting/Starvation/Effects of Purging/Healthy Eating
- Support and direction in Healthy Behaviors
- Cognitive Restructuring

# Cognitive Interventions

- Cues-avoiding
- Consequences-changing the rewards
- Thoughts/Feelings/Behaviors
- Identification of cognitive distortions
  - Overgeneralization; catastrophizing; black/white thinking; other “automatic” thoughts
  - Particularly prevalent re: weight/shape- (If I eat that, I’ll get fat; I must be thinner; He must not like me because I’m fat; Being thin is the most important thing in the world, etc)

# Treatment

- Pharmacotherapy
  - Antidepressants clearly efficacious include tricyclics, MAO inhibitors, SSRI's
  - Others probably effective but not tested
  - Bupropion contraindicated
  - Important points:
    - Antidepressants suppress B/P even in nondepressed
    - Antidepressants don't induce complete remission as often as CBT; therefore, not a sufficient treatment

# Treatment

- Pharmacotherapy
  - Fluoxetine is only FDA approved med. Rx for BN
  - Higher doses of fluoxetine work better in contrast to efficacy in depression
  - Remember, pts might vomit their antidepressants
  - Relapse can occur even in those on antidepressants
  - Other possibilities: ondansetron, topiramate

# Treatment

- Family therapy
  - Especially and perhaps differentially important in those who are young and at home vs those out on their own
- Self-help manuals (bibliotherapy) help some
- There is as yet no reliable evidence that 12-step programs work.

# Summary

- It is clear that there is evidence to base treatment plans for BN.
- Failure to learn how to do (and then doing) one or more of the specific, effective treatments for pts with BN is intolerable. It wouldn't be countenanced in any other branch of health care.
- The Academy for Eating Disorders and the APA offer courses nearly every yr in these treatments.